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Therapist actions and corresponding narrative change during therapy : a case study

Mary Clare Champion
University of Tennessee

To the Graduate Council:

I am submitting herewith a thesis written by Mary Clare Champion entitled "Therapist actions and corresponding narrative change during therapy : a case study." I have examined the final electronic copy of this thesis for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Master of Arts, with a major in Psychology.

Robert G. Wahler, Major Professor

We have read this thesis and recommend its acceptance:

Accepted for the Council:
Carolyn R. Hodges

Vice Provost and Dean of the Graduate School

(Original signatures are on file with official student records.)

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Acceptance for the Council:

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Graduate Studies

THERAPIST ACTIONS AND CORRESPONDING NARRATIVE CHANGE DURING THERAPY: A CASE STUDY

A Thesis
Presented for the
Masters of Arts
Degree
The University of Tennesee, Knoxville

Mary Clare Champion
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DEDICATION

This thesis is dedicated to my husband, Christopher Champion, and my parents, John and Jessica Younger, without whose love and support I would be lost. Thank you for helping me achieve my dreams and goals.

ACKNOWLEDGEMENTS

I wish to thank the people who helped me complete the Masters of Arts in Clinical Psychology. Most of all, I would like to thank Dr. Robert Wahler, whose guidance and support have helped me develop both clinical and research skills, and who exposed me to the power of narrative as it relates to therapy and personal growth. I would also like to thank Dr. Howard Pollio and Dr. Deborah Welsh for their input and for serving on my committee.

ABSTRACT

The purpose of this study was to investigate narrative change over the course of therapy, particularly the relationship between therapist behaviors and narrative change. To explore this relationship, one family's journey through therapy was recorded.

Therapist statements were coded for the presence of the therapist being responsive to the clients, asking for elaboration from the clients, and challenging what the clients said in therapy. Client narratives were coded and given scores on coherence, the extent to which the narratives made sense to the reader and were free from distracting remarks, and richness, the extent of detail in the narrative.

Findings reveal that coherence appeared to be a stable trait which did not change during therapy, but richness appeared to develop and grow in this case. Among therapist behaviors, asking for elaboration when needed appears to be the most important factor in leading to the corresponding growth in richness.

While these findings are an interesting first step in understanding narrative change in the therapeutic context, it is important to note that this was a case study. Limitations to this study are discussed and directions for further research are suggested.

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I. INTRODUCTION

Much of what transpires between a therapist and a client remains a mystery, despite years of research on the topic. What is universally accepted is that the relationship between a therapist and a client is a potentially powerful one, one that assists in helping a client make therapeutic progress. When a client enters therapy, the hope is that by the end of the treatment, the client will have made progress, both in his or her own eyes and the eyes of the therapist. Therapeutic rapport is a crucial aspect of successful therapy. In much of the literature, researchers use the term 'alliance' in speaking about the relationship between a patient and therapist. During the building of an alliance or therapeutic rapport, the therapist shows the client that he/she hears what the client is saying. If the relationship builds as it should, a sense of trust emerges.

The concept of therapeutic alliance is psychodynamic in origin (Horvath & Luborsky, 1993). Sigmund Freud wrote about alliance as early as 1912. Freud explained alliance as the therapist maintaining a "sympathetic understanding," from which the client could positively attach to the therapist and then engage in the therapy to a fuller extent (Freud, [1913] 1958). In Freud's model, as the therapist is interested in the client, the client can attach to the therapist with the healthy part of him/herself. Other theorists have elaborated upon Freud's introduction and have used different terms to describe this relationship. These include ego alliance (Sterba, 1934), therapeutic alliance (Zetzel, 1956), and working alliance (Greenson, 1965). Greenson's model was one with three

components, all grounded in the reality-based connection between the patient and the therapist. The three components Greenson proposed in his model were transference, the working alliance, and the real relationship (Horvath & Luborsky, 1993). Zetzel's (1956) model worked to distinguish between transference and alliance. According to Zetzel's conceptualization, the alliance is the non-neurotic part of the therapist-patient relationship. This relationship allows the client to use the interpretations of the therapist to compare past relationships and their residue to the real and present relationship between the client and therapist (Horvath & Luborsky, 1993).

Luborsky (1976) is another researcher who has continued to refine these ideas of alliance. Based on the Penn Psychotherapy Project, Luborsky put forth the idea that the alliance between a client and therapist is a living and dynamic entity, rather than a static one. In Luborsky's concept, alliance shifts and changes in response to different stages in therapy. He labeled two types of alliance, Type 1 and Type 2. Type 1 alliance is "A therapeutic alliance based on the patient's experiencing the therapist as supportive and helpful with himself as a recipient" (Luborsky, 1976, pp. 94) and Type 2 alliance is "... a sense of working together in a joint struggle against what is impeding the patient... on shared responsibility for working out treatment goals... a sense of 'we-ness'" (Luborsky, 1976, pp. 94).

Several factors affect the formation of the therapeutic relationship. Both client and therapist variables influence the relationship. In addition, both

intrapersonal and interpersonal client variables play a significant role on the alliance (Horvath & Luborsky, 1993).

In examining common factors in diverse psychotherapies, the most apparent commonality is the development of a therapeutic alliance, a relationship between the client and the therapist (Grencavage & Norcross, 1990). Across different theoretical stances, the relationship between the client and the therapist is a major component.

Once the therapist and client have formed a relationship, work begins with the intention of making change for the client. Again, there are many opinions as to how change occurs and by what it is motivated. The telling of one's stories provides an opportunity for change. Our life stories, our narratives, serve as a personal map. They help guide us through interactions in the world by helping us organize events and actions, and they help us account for our actions (Sarbin, 1986). According to McAdams (2001),

> people living in modern societies .. reconstruct the personal past, perceive the present, and anticipate the future in terms of an internalized and evolving self-story, an integrative narrative of self that provides modern life with some modicum of psychosocial unity and purpose. Life stories are based on biographical facts, but they go considerably beyond the facts as people selectively appropriate aspects of their experience and imaginatively construe both past and future to construct stories that make sense of them and to their audiences, that vivify and integrate life and make it more or less meaningful (pp. 100).

According to Hermans (1996), stories and storytelling are "guiding principles for the self" (pp. 31). Jerome Bruner (1986) and Theodore Sarbin

(1986) are often noted as advocates of narrative approaches. Bruner (1986) explained that narratives are people's attempts at grounding their experiences in time and space, they are an effort at making historical accounts. Hermans notes that the study of narratives has experienced an upsurge in the recent past, and that such work is well on its way in making a central place for itself in psychological research.

Personal narratives serve an important purpose for people. As put forth by Arciero and Guidano (2000), the composition of the personal narrative "allows one to distinguish feelings from the flow of immediate experiences" and "permits one to understand and explain feelings and experiences" (Arciero and Guidano, 2000, p.97). Narratives serve an important guiding purpose in people's ability to integrate and communicate their own experiences. In the therapeutic setting, narratives are a useful tool. According to Robert Neimeyer (2000), narratives "may be shared to lighten a client's burden of secrecy, to buttress a tentative construction of important events, to place a set of confusing events on the table of therapeutic discussion, or to give form to a dialogue between one's sensed or possible selves" (Neimeyer, 2000, p. 212). The general purpose of narrative is that it helps individuals establish continuity within their own experiences.

Not all individuals are capable for whatever reason in creating this continuity. Whereas healthy narratives have good coherence, the capability to explore narratives that concern the past, future, and present, complexity in their

details, and diversity of processes used, emotions conveyed, cognitions referenced, and meanings explored (Goncalves et. al., 2000), other narratives do not have these qualities. Narratives which do not show these capabilities can indicate pathology in the narrator. This rigidity occurs when the individual cannot reintegrate emotional discrepancies into their understanding of themselves. There is no sense of continuity. This results in a narrative which is concrete and rigid (Arciero and Guidano, 2000). Goncalves et. al. (2000) agree with Arciero and Guidano's notion that rigidity in the narrative may indicate pathology. With this rigid nature, the narrator is stuck somehow within an inflexible plot. All of the narrator's stories, whether they be current or past, are stuck within an invariant theme.

Restructuring the narratives which are fragmented and disjointed can help people clarify their goals (Singer & Salovey, 1993). This reconstruction can also help people become more aware of their identities (McAdams, 1985), as well as come to a better understanding of significant life events (Pennebaker, Colder, & Sharp, 1990) and meaningful and moving emotional experiences (Baumeister, Stillwell, & Wotman, 1990). According to Woike et. al. (1999), the structure of an individual's narrative can depend on whether or not the person is more agentic or communal, that is, if they are more concerned about individual achievement or connection to others.

Research has shown several ways in which narratives can be helpful for people, and has also commented on what types of things affect the structure of these narratives. Differences between narratives have also been explored, including their structural complexity (McAdams, 1985; Woike et. al., 1999) and their intelligibility (Baerger & McAdams, 1999). Much of the research, however, deals with a normal (McAdams, 2001; Woike et. al., 1999) rather than the clinical population. Can these stories change for people in the clinical population? We would hope that this answer is yes, that narratives shift and change through the process of therapy. But these changes do not occur while the client is in isolation. Narrative change occurs through work with another person, in this case, the therapist.

Hermans states that an important aspect of the narrative is that "it is always told... [it] cannot be separated from the act of telling. When there is a teller of a story, there is always an actual or imagined listener present who influences both what is told and the way it is told. Telling a story is telling-it-to-someone. In other words, the telling of a story is a dialogical process and in fact a co-construction between the teller and the listener (Hermans, 1996, pp. 40). In this work, the listener that Hermans describes as vital to the construction of narrative is the therapist.

No matter the orientation, all therapy is dialogic, it is conversation (Efran and Cook, 2000). The psychiatrist Thomas Szasz stated that he never treated

anyone because the people he saw were not sick. He described what he did with patients as simply talking and listening (Szasz, 1998). Although Szasz stated it rather simply, what happens within these conversations is quite powerful.

Often clients come into therapy upset and confused. They cannot make sense of who they are in the world. Their stories can be muddled and sparse, lacking clarity and detail. Their narratives are fragmented, and with this fragmentation, it is difficult for the client to absorb and assimilate new information and experiences. There is a sense of rigidity in their stories. The client tries to shove this input into their existing categories, and they can't make sense of what is happening to them. As stated before, these indicators in the narratives are markers of potential pathology (Arciero and Guidano, 2000; Goncalves et. al., 2000). According to this perspective, it is helpful to have someone, i.e., the therapist, scaffold a client's story so that it makes better sense. As the client begins therapy, the story they tell can be illogical and chaotic. At the beginning of therapy, work is done to ensure the presence of an alliance, a relationship within which progress can be made. After this groundwork is laid, work can progress. With the assistance of the therapist, the client can piece together an improved narrative, one that makes sense, one into which they can file new information. The hope is that the new narrative is more fluid and flexible, and will give the client potential to move more freely and comfortably through the world.

How does this change happen? What happens during therapy sessions that may result in change for the client? Within the therapeutic relationship, the therapist uses language which exemplifies components of the relationship and helps the client reshape their narrative. The therapist provides this scaffolding within the therapeutic relationship by being responsive, showing he/she is listening, elaborative, asking the client to build upon the story, and challenging, pointing out discrepancies in the story.

Responsiveness on the part of the therapist is a crucial component of building a therapeutic relationship. By being empathetic and willing to react to the client's appeals and efforts, the therapist beings to build a rapport with the client. This is much like Luborsky's Type 1 alliance which seems to exist in the beginning stages of therapy (Luborsky, 1976). In this study, responsiveness was measured along the aspects of appropriateness, understanding, reference, and continuity.

As a foundation is built in the alliance between client and therapist, the therapist may move onto statements which carry a stronger element of risk. By asking the client to elaborate upon what has been said, the therapist takes a more active role. The therapist gently guides the client by prompting continuation, asking for new information, asking for recapitulation, or asking the client to provide a context for what has been said. After the therapist has established a sense of trust with the client by letting the client speak freely and showing the

client that they are listening, the therapist moves into a more active role. Neimeyer (2000) provides some advice for responding to a client who gives a barren narrative, one that lacks richness. He gives the direction for the therapist to go over the details of an emotionally significant event. This gives the client an opportunity to re-examine and rearticulate what has been said previously. This process is what I refer to as prompting elaboration. This shift is similar to what Luborsky (1976) described as Type 2 alliance, where more active work is done between the client and the therapist.

Lastly, the most intrusive actions on behalf of the therapist are the statements which challenge the client. These challenges test the strength of the alliance between the client and the therapist. When the therapist challenges the client, the therapist may interrupt the client, question the coherence of the story, question the thematic quality of the story, or question the client's concept of causality.

Narrative change may be measured in several ways. In this study, narratives were scored on two dimensions, coherence and richness. Coherence measures the extent to which the narrative flows clearly and is easily understood. Richness is a measure of the level of detail and expansion in the narrative, illustrating the extent to which the narrator takes other perspectives and/or elaborates an idea past its original conception. Other people have used these terms in describing and studying narrative structure, but in different ways.

Neimeyer (2000) describes different features of a narrative apart from coherence and richness, which are used in this case study. The features Neimeyer uses are setting, characterization, plot, theme, and fictional goal. However, these characteristics are all related to what is defined as richness in this study. In Neimeyer's work, setting refers to the 'where' and 'when' of the story, characterization refers to the 'who' of the story, and plot refers to the 'what' of the story. Theme is concerned with the 'why' of the narrative, and fictional goal refers to the projected end point of the narrative. All of these components are included in our present depiction of richness.

Goncalves and his colleagues (2000) also define the structure of a narrative in slightly different terms than are used in this work. According to Goncalves (2000), a coherent narrative involves a sequence of seven elements. These are setting, initiating event, internal responses, goal, actions, outcome, and ending. While these components, which involve the narrator providing background information, the trigger for the story as well as the responses to and planned objectives concerning said trigger, the actions and results of the characters in the story, and finally the conclusion to the story, certainly make for a complete and rich story, it is my contention that it is possible with our definitions for a narrator to have a coherent story which does not follow this sequence. Again, Goncalves seems to be including aspects of what it is defined as richness in this work as coherence. In this case study, coherence concerns whether or not the story makes sense, whether or not it can be logically followed by a reader or

listener. With this conceptualization, a story can be coherent and lack richness; that is, lack the depth of detail provided by people who are more able to integrate experiences into a meaningful whole.

I contend that coherence is a stable characteristic, comparable to that of cognitive ability. Richness, on the other hand, is more fluid and can either improve with improved psychological well-being, or deteriorate with psychological distress. For example, with increased richness, an individual can move out of a previously isolated state and move into a state where he/she is able to incorporate the feelings and reactions of others into the narrative. This type of shift would be seen as therapeutic growth. In his discussion of narrative coherence, Goncalves (2000) does reference the narrative that is coherent without richness, but does not use the same terms as are used in this case study. Rather, he comments that there are narratives which make sense but lack qualitative complexity and/or dramatic engagement.

Goncalves (2000) describes narrative change in the form of increased richness, "therapeutic change corresponds to the progressive acquisition of a narrative attitude that allows clients to introduce creatively and proactively more flexibility into their narratives" (p. 275). This type of change is what I predict will occur as the individuals in this case study participate in therapy where measures were taken to encourage them to elaborate their stories and to move out of their rigidity.

Horvath and Luborsky (1993) state the need for further research to examine "specific alliance-related client experiences" (pp. 570), that will be useful in informing clinical practice. They specifically call for "more fine-grained studies aimed at identifying specific therapist actions that facilitate alliance development or the repair of a disrupted alliance in specific treatments and at different stages of therapy" (p. 570). Grencavage and Norcross (1990) also call for studies which examine the actual practices of psychotherapists. This study is one attempt to answer to Horvath and Luborsky's and Grencavage and Norcross's call in that it involves examining specific therapist behaviors and how they relate to narrative change over the course of psychotherapy. The formation of an alliance is the groundwork upon which narrative change is achieved.

II. PARTICIPANTS

Clients were a divorced couple, Edna and John, and their five-year-old daughter, Laurie. These parents came to the clinic because of concerns about the impact of their divorce on Laurie, and both pointed out that she was chronically stressed as shown through her efforts to "take care of her father" and to "persuade her mother to bring him back to the family." Edna described herself as a "savior" who was much like Laurie in this respect. John referred to himself as a "fringe person" who "barely gets by" and has always been this way. While Edna was successfully employed and financially stable, John was an admitted alcoholic who went from job to job and currently lived with a girlfriend who took care of him. The primary therapist was an experienced male clinical psychologist who was accompanied by a master's level student who was his apprentice. In all sessions, Edna, John, and the two therapists were present, with Laurie present in about ten percent of the sessions. Most of the social exchanges during sessions were between the primary therapist and the two parents.

III. INTERVENTION STRATEGIES

The primary therapist outlined his strategy as a means of promoting the parents' awareness of how all three family members were maintaining Laurie's "savior" tactics, which in turn was the basis of this little girl's stress. This strategy emerged within the first three sessions in which the therapist encouraged Edna and John to tell their stories about the marriage and their individual lives before and after the marriage ended. Edna's stories highlighted her lifelong focus on helping others, being a peacemaker, and becoming frustrated by the lack of reciprocity from those she helped. Eventually, her stories shifted to include a view of herself as control oriented because of her mistrust of others. John's stories highlighted his lifelong focus on fitting in but never seeming achieve this goal because of his inability to satisfy loved ones, friends, and employers. Eventually, his stories shifted to viewing himself as a "slick salesman" who usually got a "free ride."

The last few sessions were marked by Edna's optimism and John's pessimism, a reversal of their moods at the beginning of therapy. Both agreed that Laurie was less focused on her "savior" tactics, as was Edna, and both agreed that Laurie's stress was significantly lower. At termination, John was referred to another clinician for individual therapy.

With the permission of the family, all therapy sessions were videotaped. These taped sessions were then transcribed. Once the therapy sessions were transcribed, they were coded by trained research team undergraduate students, using two coding systems. The first coding was of therapist statements in the sessions. For every turn-taking statement made by the therapist, a trained coder answered 12 questions, four yes/no questions on each of three dimensions. These dimensions are; ***responsiveness***, which assesses whether or not the therapist showed an understanding of what the client was said, ***elaboration***, which assesses whether or not the therapist encouraged the client to elaborate what had been saying by urging them to continue or asking for new information, and ***challenging***, which assesses to what extent the therapist challenged the client's words by pointing out discrepancies or challenging the client's assumptions (see Appendix A for complete list of questions). A second coder preformed reliability checks on this codingby double coding twenty-five percent of the transcripts. In the case of a discrepancy, the primary coder's codes were used.

The transcripts were then coded a second time, this time involving the clients' narratives. In this study, only the adult narratives were coded. The first step toward coding the client narratives within the therapy sessions was to divide the sessions into narrative chapters. Narrative chapters are defined as speaker-specific units which are content sensitive. New topics indicate a chapter change, as does a change in the speaker. Defining these units was the first step of the coding process performed by trained undergraduate coders.

Client narratives were coded according to a system put forth by Castlebury and Wahler (1998) in their "Guidelines in coding the personal narratives of children, parents, and teachers". These guidelines are based on points put forth by Castlebury (1988) in an earlier work and are designed to sample coherence and richness of personal narratives. Both scale reliability (Alpha coefficients) and intercoder reliability (Intraclass coefficients) proved to be adequate, making this system suitable for use in coding adult narratives (Castlebury & Wahler, 1998).

General directions in using the system include letting the burden of proof fall to the narrator, making the narrator provide sufficient material to score "yes" on any of the coding questions. Coders are also instructed to let each chapter stand alone, to avoid letting qualities of one chapter leak into the next. Lastly, coders are directed to answer each individual question independently (Castlebury & Wahler, 1998).

Coding of coherence assesses whether or not the story makes sense, whether it flows logically. Richness concerns whether or not the story is elaborated with detail and how well the client sets a context for his/her story (see Appendix B for coding questions).

Once both sets of coding were complete, therapist statements were matched with client chapters. Each therapist statement belongs to a client chapter,

and once matched, therapist statements were collapsed into the chapters to which they belonged. These collapsed sets of therapist statements yield a composite score which is a ratio of opportunities for the therapist to be responsive, elaborative, or challenging, to the number of times the therapist was responsive, elaborative, or challenging. This results in each chapter having an overall therapist score on each dimension (*responsiveness, elaboration, challenging*), as well as a client narrative score for each dimension (*coherence, richness*).

IV. RESULTS

There was a general pattern of therapist behavior over the course of therapy. By looking at averages of therapist behaviors, it was evident that the therapist was most often responsive, and was responsive almost eighty percent of the time (mean = 3.16 out of four opportunities per statement to be responsive). About twenty-five percent of the time (mean = 0.99), the therapist saw the need to ask for elaboration. Lastly, the therapist rarely, less than two percent of the time, challenged what the clients had to say (mean = 0.05). The therapist was most often responsive to the client, showing the client that he/she was listening to what the client was saying and using the client's words. The therapist asked for elaboration less often, but asked for elaboration more during the first half of the treatment (mean = 1.16 for the first half of treatment versus mean = 0.87 for the second half). Least often the therapist was challenging, very rarely pointing out discrepancies in what the client was saying or asking confrontational questions. Table 1 shows the statistical descriptions of these trends, while Figure 1 visually shows this trend.

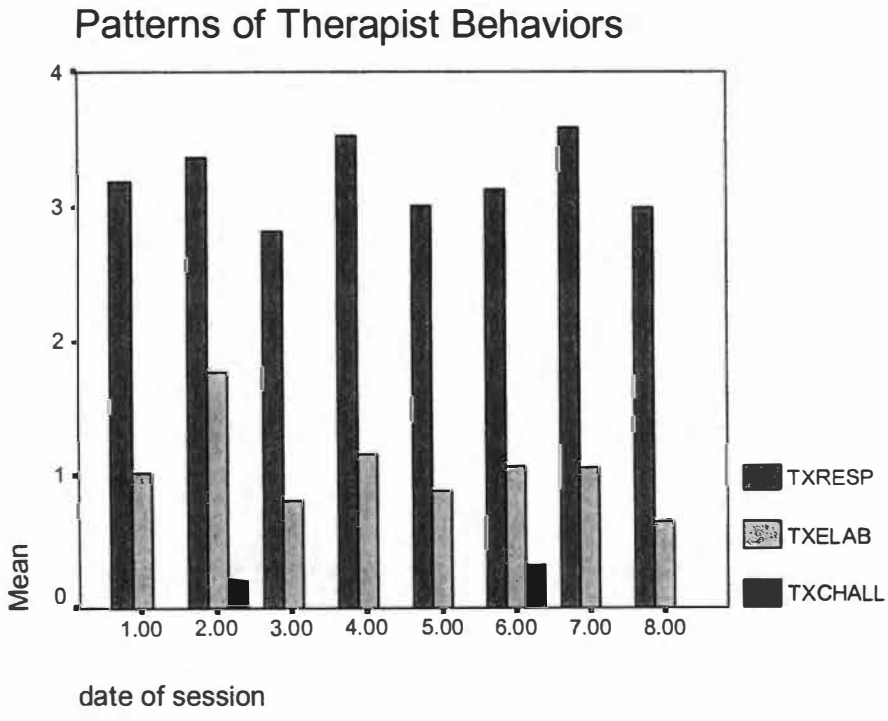
Another pattern that was noticed concerns the characteristics of the clients' narratives. Over the course of therapy, narrative coherence stayed rather stable, only showing any noticeable movement from the first session to the following session. Richness, however, was much more fluid and changing, suggesting that richness is more prone to move and change in relation to what is going on at the present. In this case, richness would be responding to the

TABLE 1

AVERAGES OF THERAPIST BEHAVIORS OVER SPAN OF TREATMENT

	All sessions	First half of treatment	Second half of treatment
Therapist responsiveness	3.16 (out of 4 opportunities)	3.18	3.14
Therapist elaboration	0.99	1.16	0.87
Therapist challenging	0.05	0.05	0.05

FIGURE 1



PATTERNS OF THERAPIST BEHAVIORS

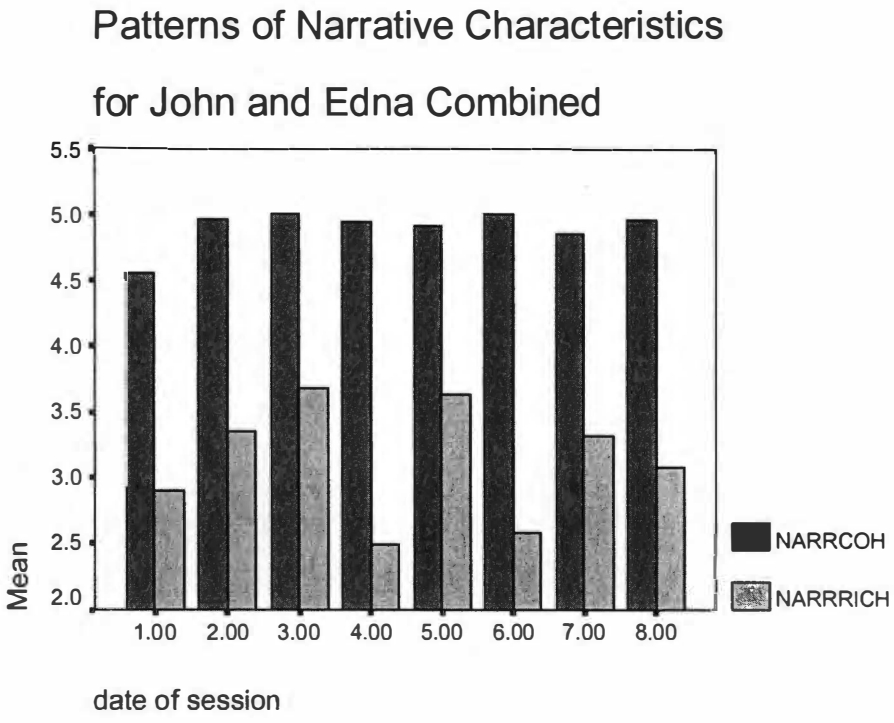
behavior of the therapist and what was going on in therapy at that time. Richness appears to fluctuate over the course of therapy for these individuals. Figure 2 shows this pattern over the course of therapy.

The next relationships explored were the correlations between the therapist behaviors and the narrative codes. Correlations were calculated comparing all of the five variables by chapters; therapist responsiveness, therapist elaboration, therapist challenging, narrative coherence, and narrative richness. Table 2 shows these correlations comparing the clients together with the therapist, while Tables 3 and 4 show these correlations comparing the two clients individually with the therapist. Whether considered together or as separate clients, the correlations did not differ in direction or significance.

Narrative coherence was not significantly correlated with any of the therapist variables. Within each client, coherence was, however, positively and significantly ($p<.01$) correlated with narrative richness, both when the two speakers were considered together and when they were considered individually.

Within the therapist variables, responsiveness and elaboration were positively and significantly correlated, as were elaboration and challenging. There was no significant correlation between responsiveness and challenging.

FIGURE 2



PATTERNS OF NARRATIVE CHARACTERISTICS FOR JOHN AND EDNA COMBINED

TABLE 2

CORRELATIONS BETWEEN THERAPIST BEHAVIORS AND CLIENT NARRATIVE CHARACTERISTICS

	Responsive	Elaboration	Challenging
Coherence	-.113	.034	.013
Richness	.325**	.325**	.040

N= 184, **p<.01

TABLE 3

CORRELATIONS BETWEEN JOHN'S NARRATIVE CHARACTERISTICS AND THE THERAPIST'S BEHAVIORS

	Coherence	Richness
Responsive	-.121	.344**
Elaboration	.016	.256*
Challenging	-.021	.103

** p<.01, *p<.05

TABLE 4

CORRELATIONS BETWEEN EDNA'S NARRATIVE CHARACTERISTICS AND THE THERAPIST'S BEHAVIORS

	Coherence	Richness
Responsive	-.104	.309**
Elaboration	.059	.385**
Challenging	.029	.025

** p<.01, *p<.05

Perhaps the most interesting correlations come when exploring the relationships between the therapist and client variables. To reiterate, narrative coherence was not significantly related to any of the therapist variables. Comparisons made with narrative richness yielded significant results. Both therapist responsiveness and therapist elaboration were positively and significantly correlated with narrative richness. Therapist challenging did not correlate significantly with either client narrative variable.

The direction and the significance of these correlations were the same when considering the clients individually and when considering them together, as they relate to the therapist.

According to stepwise regression analysis, as shown in Table 5, therapist elaboration was the only significant predictor of narrative richness ($F=21.525$, $p<.001$). Neither therapist responsiveness nor therapist challenging were significant predictors in the model.

TABLE 5

PREDICTORS OF NARRATIVE RICHNESS

	Beta	**t**	**Sig.**
Responsiveness	.179	1.714	.088
Elaboration	.325	4.639	.000**
Challenging	-.036	-.501	.617

R^2=.106, F=21.525, p<.001

V. DISCUSSION

This study attempts to contribute to a needed area in the literature, but there are limitations that are important to acknowledge. It is important to remember that this study is a case study, and although case studies are often of great value, they also have certain weaknesses. Case studies are of value in that they help researchers define other areas of further research as they generate ideas which can be looked in to on a larger level. Case studies have also been useful as a source for the development of therapy techniques. They allow us to study situations which are rare, and to test laws which are considered to be universal and therefore, applicable to individuals. Lastly, they are of value in that they motivate and persuade us. While these strengths show us what case studies can contribute to the body of scientific literature, it is also important to note their weaknesses. Historically, case studies have not used systematic observation, nor have they used controlled conditions, making it possible for other alternative hypotheses to explain the observed outcomes. It is also difficult to explain how the results of a case study can generalize to the larger sphere (Kazdin, 1992). The results of this study should be interpreted with these limitations in mind.

In considering the therapist behaviors (i.e., being responsive most of the time, asking for elaboration less of the time, and rarely being challenging) it is possible that the therapist adheres to this hierarchy because he was building a relationship with the client. In this relationship, the therapist urges the client

along, showing he is listening and asks for new information when he needs it. As the client and therapist move along like this, there is rarely a need to challenge what the client has to say. For the therapist, asking for elaboration allows him/her to prod the clients for more information and to encourage them to say more about a specific item. Perhaps with this nudge, the client has an opportunity to think back over something and interpret it in a new light.

According to present results, narrative coherence appears to be a stable quality in stories told by these particular adults. Rather than coherence moving with therapy, it stayed fairly constant with little change for either of the therapy participants. However, these results pose an interesting notion about the nature of narrative richness. In this case study, the richness of the clients' narratives was significantly related to two of the coded therapist behaviors, but as shown by the regression analysis, elaboration was the significant therapist behavior, and the significant correlation with responsiveness was an artifact of its correlation with elaboration . As the therapist was more responsive to what each client was saying, the clients made their narratives more rich. Likewise, as the therapist asked for more elaboration in the stories, the clients added more richness to their narratives. The therapist rarely challenged what the clients were saying, and perhaps this can be explained by there not being a need for the therapist to challenge the clients. As the therapist has helped the clients negotiate their story, the therapist has been there to ask questions and scaffold the narrative. With this scaffolding, there have been fewer opportunities for there to be gaps or

inconsistencies in the narrative. Through being responsive and urging the clients to elaborate, the therapist helps them shape the richness of these stories along the way. This nurturing effort is less jarring than confrontational challenging of the narrative. The client is encouraged to explore their narrative, and it is hoped that a safe environment has been established from which this exploration can occur. The client and the therapist work as a team, trying to understand the client's stories of the past as well as the present. This combined effort leaves little need for the therapist to challenge information that the clients present.

Within this study, narrative coherence appears to be a stable trait-like factor, while narrative richness is more state-related, moving in relation to behaviors by other people, in this case, the therapist. Thus, coherence can be thought of as foundation-like property. In order to string a sensible story, one must be coherent. In being coherent, your thoughts make sense, are able to be followed by a listener or reader, and are free from comments or thoughts that detract from your message. It is possible for a narrative to be coherent, for it to make logical sense, and for it to lack richness. In this scenario, the narrative would be sensible, but something would be missing.

Richness, as suggested by this study, is a powerful construct in considering the make-up of a narrative. Narratives that are rich are able to convey one's message with more power and more detail. Ideas are elaborated past their initial introduction and the speaker shows an ability to take other people's

perspectives. With more richness, narratives are able to be more accurate and show more nuances.

As a person is able to build upon narrative coherence with richness, the amount of flexibility in the narrative increases. The story can be told many ways. In increasing this flexibility, there is more opportunity for connection. The speaker is able to communicate in more detail with others, and is able to show that they are considering the points of view of others.

Why might narrative richness be associated with therapeutic change? With John and Edna, follow-up information is limited, although it is known that they did not return to the clinic for further assistance, as they were advised to do should the need arise. At the end of therapy, Edna reported being pleased with her progress and felt that therapy had helped her family. John was less pleased at the end of therapy. During therapy, John and Edna were encouraged to elaborate upon the metaphors which they employed in their narratives, including Edna's notion of being a "savior" and John's feeling like a "victim." With this opportunity, John and Edna had the chance to safely explore these metaphorical maps that they had used during their lives, the narrative maps that had led them through life and helped them gather and assimilate information. Picture that before therapy, John and Edna were wearing 'horseblinders' which limited their range of vision. These 'horseblinders' were their metaphors of being the "savior" and the "victim," and they limited John and Edna's perspectives on their lives.

During therapy, these 'horseblinders' were slowly removed, allowing them to see more of what was going on around them, and to think more about these metaphors they had constructed. This removal was aided by the therapist's guidance in asking for elaboration when needed, prompting John and Edna to reassess and expound on what they had been saying. At the end of therapy, Edna had begun to understand her notions of being a "savior" and was gaining insight of her need for control based in her mistrust of others. Although this information was difficult for Edna to discover and understand about herself, she was optimistic about her growth and the future. As mentioned earlier, John was less optimistic about his revelations, and his realizations of feeling like a "slick salesman" who often got a "free ride." These different outlooks may be related to John and Edna's readiness for therapy. Although both of them were willing participants, they began therapy at Edna's instigations. Edna may have been more able to handle the difficult information she encountered because she was more ready for therapeutic work.

If narratives are envisioned as maps we follow, imagine that before therapy, John and Edna's maps were rudimentary, showing only major thoroughfares and routes, the 'interstates.' After therapy, the map was much more detailed, showing the 'rural highways' and the 'scenic routes.' After therapy, the maps are more intricate, and there are many more options for how to get from one point to another, versus the one option which was visible in the original map.

It has been suggested that richness reflects a person's motivation to inform a listener (Rogers, 2002). Perhaps in John and Edna's case, richness fluctuated through therapy because at different times, they were more motivated to inform the therapist of their thoughts and feelings. Once they had become engaged in therapy and had formed a relationship with the therapist, they were more motivated to share with the therapist, and as this desire grew, so did the richness of their narratives. As the therapist becomes more knowledgeable, the clients may feel less push to provide new information for him, and their stories could drop in richness at those points as a reflection of this decline in motivation.

In taking this discussion of richness further, perhaps the presence of richness in a narrative, or the growth of richness over time, is related to a person's well-being. Having this richness present suggests flexibility, the ability to take other perspectives, and the ability to make distinctions in the world. Persons who have this ability have a sense of mindfulness, an awareness of the world around them. A narrative that is coherent but not rich lacks detail and flexibility. It is rigid, and rigidity is considered to be a sign of pathology. Over the course of therapy, the richness of John and Edna's narratives fluctuated over time, growing and retreating from session to session. Perhaps this pattern of mobility was related to what topics they were working on and the level of comfort they each felt in delving into specific material. At approximately the mid-point of therapy, there seemed to be a peak in the richness of John and Edna's narratives. Perhaps at this point in therapy they were particularly engaged with the therapist, and were

especially motivated to connect with the therapist by sharing new information and new insights on former discussions.

It is important to note that this observation concerning the nature of narrative coherence is made through the observation and study of two adults from a clinically significant population who were seeking treatment and were seen for approximately ten sessions by both a faculty and a student therapist. Perhaps coherence is mobile in response to therapy, but meaningful movement in coherence may be a slower process made over a longer period of time than what was studied in his case study. In this study, however, coherence grew slightly from the first session to the next, but stayed relatively stable for the duration of the treatment. Also, the clients whose narratives have been examined are considered to be from a clinically significant population. Adults without significant pathology might produce narratives with different qualities and respond differently to the prompts of others.

The narratives studied here are those of adults. It is beyond the scope of this work to address children's narratives. Although not addressed, it would be helpful in understanding the formation and behavior of children's narratives to study them in such a manner as described in this paper.

A limitation of this study is the possible impact on the division of therapy sessions into narrative chapters. Since the narrative chapters were topic specific,

there is the possibility that coherence scores were inflated. This possibility comes from the division of chapters by topic making it less likely for the question concerning tangential remarks to be endorsed. What could be considered a topic shift, and hence a new narrative chapter, might also be considered a tangential remark in relation to the original thought being presented. However, this condition seems to have very little effect when looking at richness scores. The presence of tangential remarks has an impact on both coherence and richness scores, and while coherence for both clients remained fairly high and consistent, there was significant movement in both of their richness scores. If the methods used to divide narratives into chapters had any impact, it does not seem to be significant.

In Hermans (1996) paper, he includes as an implication for further research, the impact of others on the construction of narrative. In this paper, the impact of a therapist upon the narratives of two clinically significant adults was explored. Hermans does not include the impact of a therapist in his suggestions, but does mention the effect of peers or a respected older person. Does the individual tell different stories around different people? Are the resulting narratives conflictual (Hermans, 1996)? To extend the results presented in this paper, comparisons could be made between narratives told with peers as opposed to clinicians.

Another possible direction for study in relation to the results found here could include measures to assess alliance. Perhaps alliance is a moderating variable in the resulting narrative changes. A stronger alliance could facilitate quicker and more robust narrative changes. Possible measurements are the California Psychotherapy Alliance Scales (Mamar, Weiss, & Gaston, 1989); the Penn Helping Alliance scales (Alexander & Luborsky, 1987); the Therapeutic Alliance Scale (Marziali, 1984); and the Vanderbilt Therapeutic Alliance Scale (Hartley & Strupp, 1983). These measurement tools are acceptable psychometrically and may be used as an observer's rating scale or a self-report measure (Horvath & Luborsky, 1993).

LIST OF REFERENCES

Alexander, L. B., & Luborsky, L. (1987). The Penn Helping Alliance Scales. (In L. S. Greenberg & W. M. Pinsof (Eds.), *The psychotherapeutic process: A research handbook* (pp. 325-366). New York: Guilford Press.)

Arciero, G., & Guidano, V. F. (2000). Experience, explanation, and the quest for coherence. In R. A. Neimeyer & J. D. Raskin (Eds.) *Constructions of disorder: Meaning-making frameworks for psychotherapy* (pp. 91-118). Washington, D.C.: American Psychological Association.

Baerger, D. & McAdams, D. P. (1999). Life story coherence and its relation to psychosocial well-being. *Narrative Inquiry, 9*, 69-96.

Baumeister, R. F., Stillwell, A., & Wotman, S. R. (1990). Victim and perpetrator accounts of interpersonal conflict: Autobiographical narratives about anger. *Journal of Personality, 59*, 994-1005.

Bruner, J. S. (1986). *Actual minds, possible worlds*. Cambridge, MA: Harvard University Press.

Castlebury, F. D. (1988). Personal narratives as maps of the social ecosystem. Unpublished paper. The University of Tennessee, Knoxville, Psychology Department.

Castlebury, F. D. & Wahler, R. G. (1998). Guidelines in coding the personal narratives of children, parents, and teachers. Unpublished manuscript. The University of Tennessee.

Efran, J. S., & Cook, P. F. (2000). Linguistic ambiguity as a diagnostic tool. In R. A. Neimeyer & J. D. Raskin (Eds.) *Constructions of disorder: Meaning-making frameworks for psychotherapy* (pp. 121-144). Washington, D.C.: American Psychological Association.

Freud, S. (1958). The dynamics of transference. (In J. Starchey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (pp. 99-108). London: Hogarth Press. (Original work published 1912).)

Goncalves, O. F., Korman, Y., & Angus, L. (2000). Constructing psychopathology from a cognitive narrative perspective. In R. A. Neimeyer & J. D. Raskin (Eds.) *Constructions of disorder: Meaning-making frameworks for psychotherapy* (pp. 265-284). Washington, D.C.: American Psychological Association.

Greenson, R. R. (1965). The working alliance and the transference neuroses. *Psychoanalysis Quarterly*, 34, 155-181.

Grencavage, L. M., & Norcross, J. C. (1990). Where are the commonalities among the therapeutic common factors? *Professional Psychology: Research and Practice, 21*, 372-378.

Hartley, D. E., & Strupp, H. H. (1983). The therapeutic alliance: Its relationship to outcome in brief psychotherapy. (In J. Masling (Ed.), *Empirical studies in analytic theories* (pp. 1-37). Hillside, NJ: Erlbaum.)

Hermans, H. J. (1996). Voicing the self: From information processing to dialogical interchange. *Psychological Bulletin, 119*, 31-50.

Horvath, A. O., & Luborsky, L. (1993). The role of the therapeutic alliance in psychotherapy. *Journal of Consulting and Clinical Psychology, 61*, 561-573.

Kazdin, A. E. (1992). Methodological issues and strategies in clinical research. Washington, DC: American Psychological Association.

Luborsky, L. (1976). Helping alliances in psychotherapy. (In J. L. Cleghorn (Ed.), *Successful psychotherapy* (pp. 92-116). New York: Brunner/Mazel.)

Marmar, C., Weiss, D. S., & Gaston, L. (1989). Toward the validation of the California Therapeutic Alliance Rating System. *Psychological Assessment: A Journal of Consulting and Clinical Psychology, 1*, 46-52.

Marziali, E. (1984). Prediction of outcome of brief psychotherapy from therapist interpretive interventions. *Archives of General Psychiatry*, 41, 301-305.

McAdams, D. P. (1985). *Power, intimacy, and the life story: Personological inquiries into identity*. Chicago: Dorsey Press.

McAdams, D. P. (2001). The psychology of life stories. *Review of General Psychology, 5*, 100-122.

Neimeyer, R. A. (2000). Narrative disruptions in the construction of the self. In R. A. Neimeyer & J. D. Raskin (Eds.) *Constructions of disorder: Meaning-making frameworks for psychotherapy* (pp. 207-242). Washington, D.C.: American Psychological Association.

Pennebaker, J. A., Colder, M., & Sharp, L. K. (1990). *Accelerating the coping process. Journal of Personality, 58*, 528-537.

Rogers, D. (2002) Reconciling personal narrative concepts: The clinical implications of perspectives on mental representation. Unpublished paper, University of Tennessee, Knoxville.

Sarbin, T. R. (1986). The narrative as a root metaphor for psychology. (In T. R. Sarbin (Ed.), *Narrative psychology: The storied nature of human conduct* (pp. 3-21). New York: Praeger.)

Singer, J. A. & Salovey, P. (1993). *The remembered self.* New York: Free Press.

Sterba, R. F. (1934). The fate of the ego in analytic therapy. *International Journal of Psychoanalysis, 115*, 117-126.

Woike, B., Gershkovich, I., Piorkowski, R., & Polo, M. (1999). The role of motives in the content and structure of autobiographical memory.

Zetzel, E. R. (1956). Current concepts of transference. *International Journal of Psychoanalysis, 37*, 369-376.

APPENDIX

Appendix A: Therapist Coding Questions

Responsiveness

1. Was the listener's response timely and appropriate?
2. Did the therapist acknowledge an understanding of the narrative?
3. Did the listener reference the speaker's words directly or through paraphrase?
4. Did the listener contribute to the continuity of the speaker's story?

Elaboration

1. Did the listener prompt the speaker to continue the story?
2. Did the listener ask for new information about the narrative?
3. Did the listener ask the speaker to review or summarize the current narrative?
4. Did the listener ask the speaker to provide context to the narrative?

Challenging

1. Did the listener interrupt the speaker's narrative?
2. Did the listener question the coherence of the speaker's narrative?
3. Did the listener question the thematic quality of the speaker's narrative?
4. Did the listener question the speaker's concept of causality?

Appendix B: Rater questions for coding client narratives

Coherence

1. Upon reading the narrative do you as the listener clearly get the point (or points) made by the narrator?
2. Are all the ideas or happenings presented by the narrator relevant to the question being asked?
3. Does the narrator's response follow a clear progression (beginning, middle, end)?
4. Is the narrator's response free of tangential remarks?
5. Do the parts of the narrator's response fit together to form a sensible whole?

Narrative Richness

1. Is at least one idea or happening introduced by the narrator elaborated beyond its initial introduction?
2. Is at least one specific or concrete event described?
3. Is the narrator's response free of vague or ambiguous thought?
4. Does the narrator support a presented idea or happening with evaluative remarks?
5. Does the narrator provide information with regard to others?

Vita

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